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7
8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

10 In the Matter of the Accusation Against:

Case No. *2010-667*

11 **CAROL ANN HEAD**

A C C U S A T I O N

12 **P.O. Box 1710**
13 **Ashfork, Arizona 86320**

14 **Registered Nurse License No. 436782**

15 Respondent.

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17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.E.D., RN ("Complainant") brings this Accusation solely in her
20 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),
21 Department of Consumer Affairs.

22 **Registered Nurse License**

23 2. On or about May 31, 1989, the Board issued Registered Nurse License Number
24 436782 to Carol Ann Head ("Respondent"). The registered nurse license was in full force and
25 effect at all times relevant to the charges brought herein and will expire on September 20, 2010,
26 unless renewed.

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1 8. On or about June 3, 2009, pursuant to Findings of Fact, Conclusions of Law and
2 Order No. 08A-0702024-NUR, in the disciplinary action entitled *In the Matter of Professional*
3 *Nurse License No. RN138718 Issued to: Carol Ann Head, aka Holvey*, the Arizona Board revoked
4 Respondent's nursing license.

5 9. The Arizona Board found that Respondent had been terminated or resigned from
6 Arizona hospitals for her inability to practice nursing duties safely as follows;

7 a. On or about May 25, 2006, Respondent was terminated from Flagstaff Medical
8 Center located in Flagstaff, Arizona, for difficulty with the hospital's information system,
9 location of equipment, and day-to-day tasks.

10 b. On or about December 16, 2006, Respondent resigned and was ineligible for rehire
11 from the Surgical Services Department at Yavapai Regional Medical Center ("YRMC")
12 located in Prescott, Arizona. Her 90-day evaluation from YRMC indicated she needed
13 improvement in all areas except ethics and collaboration.

14 c. On or about October 29, 2007, Respondent was terminated from North County
15 Community Health Center ("NCCHC") located in Ashfork, Arizona. On or about
16 February 8, 2007, while employed at NCCHC, a complaint was received by the Arizona
17 Board that Respondent failed to demonstrate competence in administering vaccines to
18 children. Additionally, Respondent discarded a telephone message from a patient which
19 she should have placed in the patient's chart. On or about October 25, 2007, while
20 employed at NCCHC, a patient complained that Respondent took 20 minutes to draw
21 blood, seemed nervous, and talked to herself while drawing blood. The patient
22 complained that Respondent stuck both her and her husband 3 times while drawing blood,
23 left blood running down their arms, caused bruising, did not wear gloves while drawing
24 blood, and asked the patient if she had Hepatitis C.

25 d. On or about November 12, 2007, Respondent became employed at Prescott Samaritan
26 Village ("PSV") in Prescott, Arizona. On or about January 8, 2008, while employed at
27 PSV, Respondent was placed on a performance plan for leaving medications at residents'
28 bedsides, having medications out of place on the medication cart, and residents feeling

1 hesitant to take medications from her. On or about February 11, 2008, while employed at
2 PSV, Respondent was placed on a second performance plan for continuing issues with the
3 administration of medication. On or about February 19, 2008, while employed at PSV,
4 Respondent made a medication error when she administered the wrong dose of Xanax to a
5 resident. On or about February 23, 2008, while employed at PSV, Respondent was placed
6 on a third performance plan for continuing issues with the administration of medication.

7 10. On or about March 19, 2008, the Arizona Board reviewed the Investigative Report
8 and voted to offer Respondent a Consent Agreement for an indefinite suspension pending
9 successful completion of a Board-approved refresher course, to be followed by 24-month
10 probation with terms. On or about April 11, 2008, in a telephone conversation with an Arizona
11 Board staff, Respondent requested to voluntarily surrender her nursing license.

12 11. On or about May 9, 2008, the Arizona Board sent Respondent a 5-year Consent for
13 Voluntary Surrender to consider. Respondent failed to sign the agreement. On or about June 5,
14 2008, Respondent sent in two separate letters to the Arizona Board agreeing to voluntarily give
15 up her Arizona nursing license but stated that she was not willing to sign the Consent for
16 Voluntary Surrender. With each letter, Respondent included a copy of her Arizona nursing
17 license.

18 12. On or about June 6, 2008, the Arizona Board sent Respondent a letter advising her
19 that her license could not be voluntarily surrendered simply by returning it to the Arizona Board.
20 Respondent was advised that a signed Consent for Voluntary Surrender was required.
21 Respondent failed to sign.

22 13. On or about July 22, 2008, the Arizona Board sent Respondent a letter advising her
23 that her case was being transferred to the Hearing Department. The letter also advised
24 Respondent of all options available to her. Respondent never contacted the hearing staff.

25 14. On or about January 7, 2009, the Arizona Board sent Respondent a 3-year Consent
26 for Voluntary Surrender to consider. Respondent was asked to return the agreement by January
27 31, 2009 in order to close her case. Respondent failed to sign the agreement.

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